TRIAD BENEFITS

# EMPLOYEE ENROLLMENT FORM

## CHANGE TYPE:

☐ New Hire ☐ Qualifying Event Employer: _____

## SECTION 1 – EMPLOYEE INFORMATION

| First Name | Last Name | Date of Birth | Gender | Social Security # | Marital Status |
|---|---|---|---|---|---|
| | | | | - - | |

| Home Address | City | State | Zip Code | County |
|---|---|---|---|---|
| | | | | |

| Home Phone | Date of Hire | Hours Per Wk | E-Mail Address: |
|---|---|---|---|
| | | | |

## PRODUCT / PLAN SELECTION

Medical / RX **Plan Options**: ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $3,500 HSA ☐ $5,000 HSA ☐ $7,350

☐ Employee Only ☐ Employee / Spouse ☐ Employee /Child (ren) ☐ Employee/Children ☐ Family

**Network Options:** ☐ PHCS ☐ United ☐ Cigna

## SECTION 2 – DEPENDENT INFORMATION (Attach a separate sheet if necessary)

| **1.** First Name | Last Name, M.I. | Date of Birth | Gender | Social Security # |
|---|---|---|---|---|
| | | | | - - |

Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Benefits Elected: ☐ Medical | Address (if different from applicant)

| **2.** First Name | Last Name, M.I. | Date of Birth | Gender | Social Security # |
|---|---|---|---|---|
| | | | | - - |

Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Benefits Elected: ☐ Medical | Address (if different from applicant)

| **3.** First Name | Last Name, M.I. | Date of Birth ☐ | Gender | Social Security # |
|---|---|---|---|---|
| | | | | - - |

Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Benefits Elected: ☐ Medical | Address (if different from applicant)

| **4.** First Name | Last Name, M.I. | Date of Birth | Gender | Social Security # |
|---|---|---|---|---|
| | | | | - - |

Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Benefits Elected: ☐ Medical | Address (if different from applicant)

| **5.** First Name | Last Name, M.I. | Date of Birth | Gender | Social Security # |
|---|---|---|---|---|
| | | | | - - |

Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Benefits Elected: ☐ Medical | Address (if different from applicant)

| **6.** First Name | Last Name, M.I. | Date of Birth | Gender | Social Security # |
|---|---|---|---|---|
| | | | | - - |

Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Benefits Elected: ☐ Medical | Address (if different from applicant)

## SECTION 3 - OTHER HEALTH COVERAGE

☐ Yes (complete below) ☐ No

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

| Name, phone number, and address of insurance company: | Policy /certificate # | Effective Date |
|---|---|---|
| | | |

| Policy/ certificate holder's name | Social Security Number | Date of birth | Relationship to applicant |
|---|---|---|---|
| | | | |

**If you and/ or your dependents are enrolled in Medicare Part A or Medicaid, complete the following.**

| Enrollee's name(s) | Medicare/ Medicaid ID# | Part A effective date | Part B effective date | ESRD onset date |
|---|---|---|---|---|
| | | | | |

Reason for Medicare entitlement:
☐ Age ☐ Disability ☐ ESRD ☐ ESRD (End Stage Renal Disease) & Disability

## SECTION 4 - SIGNIFICANT TERMS, CONDITIONS, AND AUTHORIZATIONS (TERMS)

Please read this section carefully before signing the application

1. I may not assign any payment under this program.

2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.

3. I am applying for the coverage selected on this application. If I select a coverage not available to me and/or a class of which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.

4. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I also acknowledge that the healthcare fees for this plan are deducted pre-tax, requiring the deductions to remain in effect during the plan year, unless there is a change of status as allowed under IRS regulations. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in cancellation of my coverage(s).

Any person who, with intent to defraud or knowing that he or she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

**Read the TERMS section above carefully before signing. Please review your application for errors or omissions.**

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

| Applicant Signature | Date |
|---|---|
| | |

## WAIVER of health coverage for employee and/ or any eligible dependent(s) not enrolling

| Name of person(s) waiving | Already protected by coverage of: |
|---|---|
| | |

| Employer name | Carrier (give name, ID#) |
|---|---|
| | |

**Check if applies**

☐ I certify that I have been given an opportunity to apply for health coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within the timeframe for timely submissions, noted in the plan document. My dependents(s) or I may be subject to waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within the specified timeframe, listed in the plan document after the marriage, birth, adoption or placement of adoption.

| Applicant signature | Date |
|---|---|
| | |